DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health

Health Systems Protection Section

Medical Marijuana Program

Instructions and Application For

Registration as a Medical Marijuana Patient

Applicant - Print Name (First/MI/Last)

Applications are NOT accepted in Person.
All applications must be mailed to the Department.

MAIL TO:
Delaware Division of Public Health
ATTN: Medical Marijuana Program
Suite 205 / HSP ADM
417 Federal Street
Dover, Delaware 19901

***** FOR OFFICE USE ONLY *****	
Approved By:	
Date of Approval:	
Registration Number:	

Revised August 3, 2012 drb

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Medical Marijuana Program

Mail to: Delaware Division of Public Health
ATTN: Medical Marijuana Program
Suite 205 / HSP ADM
417 Federal Street
Dover, Delaware 19901

Please note that this checklist, information and other instructions may change. Please refer back to the Delaware Health and Social Services (DHSS) website for the most current information. Review this checklist prior to submitting your application. This checklist will assist you in compiling the required information and supporting documentation. Updates to the program and contact information can be found at the program's website (http://dhss.delaware.gov/dhss/dph/hsp/medmarhome.html).

Application Checklist

Patient without Caregiver

- ☐ Qualifying Patient Application (attestation statement must be signed)
- ☐ Physician Certification (completed and signed by the patient's physician)
- ☐ Patient Application Fee (**non-refundable**) in the amount indicated in the schedule of fees (**Payment in the form of a personal check or cashier's check, payable to State of Delaware, Medical Marijuana Program)**
- ☐ Release of Medical Information form (signed by the patient)
- ☐ **Copy** of Delaware state driver's license or state-issued identification (bring original for visual inspection when you have your photograph taken)

Patient with Caregiver

- ☐ Qualifying Patient Application - Attestation statement must be signed
- ☐ Physician Certification (completed and signed by the patient's physician)
- ☐ Patient Application Fee (**non-refundable**) in the amount indicated in the schedule of fees (**Payment in the form of a personal check or cashier's check, payable to State of Delaware, Medical Marijuana Program)**
- ☐ Release of Medical Information form (signed by the patient)
- ☐ **Copy** of Delaware state driver's license or state-issued identification (bring the original for visual inspection when you have your photograph taken)

- ☐ Qualifying Caregiver Application - attestation statement must be signed
- ☐ Caregiver Application Fee (**non-refundable**) in the amount indicated in the schedule of fees (**Payment in the form of a personal check or cashier's check, payable to State of Delaware, Medical Marijuana Program)**
- ☐ Patient Authorization form (authorizing caregiver to assist the patient in the transportation of medical marijuana)
- ☐ **Copy** of Delaware state driver's license or state-issued identification for the caregiver
- ☐ **Copy** of caregiver's birth certificate (verifying caregiver applicant is at least 21 years old)
- ☐ Statewide and nationwide criminal history screening background clearance reports for the caregiver (for further information, contact the program)

Registration Requirements

Requirements for Patients

The following requirements are for people who wish to register with the Delaware Medical Marijuana Program as a qualified patient.

* Must be a DE resident and have a Delaware state-issued driver's license or identification Card.
* Must be at least 18 years of age to apply for a patient registration.
* Must complete and sign the qualifying patient application.
* Must be diagnosed with one of the qualifying debilitating conditions listed on the application.
* Must have the patient's physician complete and sign a Physician Certification form.
* Must submit a Release of Medical Information form to allow the program to verify their medical condition with the certifying physician.
* Must submit a non-refundable application fee with the application. (See schedule of fees for details.)
* May designate one caregiver and submit caregiver application and supporting documentation along with the patient's application. (See Requirements for Caregivers section).

Requirements for Caregivers

The following requirements are for people who have been selected by a Medical Marijuana Program patient to help them with transportation of marijuana, and wish to be registered in the Delaware Medical Marijuana Program as a caregiver.

* Caregiver information and applications are ALWAYS provided by the patient.
* Must be a DE resident and have a Delaware state-issued driver's license or identification Card.
* Must be at least 21 years of age to apply for a caregiver registration.
* Must complete and sign the qualifying caregiver application.
* Must have patient sign the Patient Authorization for Caregiver form, authorizing the caregiver to assist the patient with the transportation of marijuana.
* Must submit a non-refundable application fee with the application. (See schedule of fees for details.)
* Each caregiver may be responsible for up to five (5) patients, including themselves if they are also a patient.

Rules and Regulations

General Information

Processing Time:

The application process can take 8-12 weeks depending on the individual circumstances; however, it is the intention of the program staff to disperse cards within 4-6 weeks from the date the completed application is accepted.

Confidentiality:

For confidentiality purposes, information regarding application status will NOT be given over the phone. Once applications are approved, a letter will be mailed to the applicant including an appointment time to have a photo taken and finalize the application process.

Information Changes:

By law, Medical Marijuana patients are required to provide DHSS with any changes in application information, such as address, phone number, chosen caregiver, etc. within 10 days of the change. After a registration card is issued, information changes will be made by completing a Change Form, available online at the program website at:

http://dhss.delaware.gov/dhss/dph/hsp/medmar.html.

Card Replacement:

There is a $20.00 fee to print a new card. Any information on a registry card that has changed, such as address, requires a new card to be printed. If a card is lost, it will also require a reprint. Please notify DHSS immediately if a registration card is lost. The program will issue a different identification number and schedule an appointment time to issue a replacement card.

Fines Established for Not Following the Program Regulations:

Fines are established in the Medical Marijuana Act for registry participants who do not follow the rules and regulations of the Medical Marijuana Program. They are listed below for your information.

Failure to notify program staff of patient or caregiver changes	$ 150.00
Selling marijuana to a non-card holder	$ 2,000.00
Fraudulent card creation or use	$ 1,150.00
Unethical professional conduct	$ 3,000.00

Fee Schedule

The following fee schedule has been established for the program. Applicants must include payment, in the form of a personal check or cashier's check, payable to State of Delaware, Medical Marijuana Program, with the application, mailed to the address on the first page of this packet. If you believe that you qualify for the low income sliding fee schedule, please contact our office for more information.

Patient Application Fee - registration effective for one year	$ 125.00
Caregiver Application Fee - registration effective for one year	$ 125.00
Patient Renewal Fee	$ 125.00
Caregiver Renewal Fee	$ 125.00
Return Check Fee	$ 35.00
Replacement Card Fee (lost card, name or address change, etc.)	$ 20.00

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Medical Marijuana Program

DPH/HSP office use only

Date Received _____ Issue Date _____

Staff Initials _____ Expiration Date _____

☐ Approved ☐ Denied App/Den Date _____

Please print clearly. Incomplete applications will be denied. Denied applicants are required to wait six months before applying again with another application fee. Please put "N/A" if not applicable. Application fees are non-refundable. **Faxed and electronic copies will not be accepted.**

Patient Application

☐ New Patient ☐ Renewing Patient Current Registry ID Card # _____

Contact Information

Date of birth _____ Gender ☐ Male ☐ Female

Must be at least 18 mm / dd / yyyy

Name _____

Title First Middle initial Last Suffix(es)

(This name must match the name on your State Issued Photo ID or Driver's License.)

Residence address The address provided below must be your physical residence and will appear on your registry card.

Apt#/development/apartment name _____

Street address/post office box # _____

City _____ State ____ County _____ ZIP code _____

Mailing address ☐ Check if mailing address is the same as residential.

Apt#/development/apartment name _____

Street address/post office box # _____

City _____ State ____ County _____ ZIP code _____

Primary phone number _____ Type of phone (home, cell) _____

Secondary number _____ Type of phone (home, cell) _____

E-mail address _____

Note regarding E-mail: Please note that confidential and time sensitive information will be sent to this e-mail address. Failure to respond to e-mails may result in your application being delayed, withdrawn or denied. It is the applicant's responsibility to add MedicalMarijuanaDPH@state.de.us to their list of safe senders to avoid having messages sent to their junk e-mail folder. Instructions on how to add an e-mail address to your list of safe senders can be found in your e-mail provider's documentation. ***It is not required that you submit your e-mail address***.

Physician Information

The following information relates to the patient's physician who completes the Physician Certification form. If the qualifying patient's debilitating medical condition is Post-Traumatic Stress Disorder, the physician must also be a licensed psychiatrist. This information should be provided by the physician on the Physician Certification form and can be copied from there.

Name _____

Title First Middle initial Last Suffix(es)

Practice/group name (if applicable) _____

Address (suite/room number, etc.) _____

Number & street _____

City, state, & zip _____

Phone number _____ Fax number _____

License number _____ License state ____ License type _____

Length of time the patient has been under the care of this Physician (years &/or months) _____

Debilitating Medical Condition

Patient's Debilitating Medical Condition (please check all that apply)

- ☐ Cancer
- ☐ Positive status for human immunodeficiency virus (HIV positive)
- ☐ Acquired immune deficiency syndrome (AIDS)
- ☐ Decompensated cirrhosis (Hepatitis C)
- ☐ Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease)
- ☐ Agitation of Alzheimer's disease
- ☐ Post-traumatic stress disorder (PTSD) (physician MUST be a licensed psychiatrist)

A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:

- ☐ Cachexia or wasting syndrome
- ☐ Severe, debilitating pain, that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects
- ☐ Intractable nausea
- ☐ Seizures
- ☐ Severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis

Any other medical condition or its treatment **added by DHSS** as provided for in 4906A of the Delaware code. Please specify below.

☐ Other: please specify _____

_____

_____

Caregiver Information

This group of questions relate to the patient's designated caregiver. A patient does not have to choose a caregiver, but if a caregiver is chosen, the caregiver must also apply for a registry identification card along with the patient. A caregiver can have up to five patients, including themselves if they are a qualifying patient, that they are caring for with regards to this program. A visiting patient may not assign a caregiver or be a caregiver for another patient.

☐ Check here if you are not requesting a caregiver, then go to the next section.

Name _____
Title First Middle initial Last Suffix(es)

Address

Apt#/development/apartment name _____

Street address/post office box # _____

City _____ State ____ County _____ ZIP code _____

Phone number _____ Phone type (cell/home) _____

Date of birth _____ Gender ☐ Male ☐ Female
mm / dd / yyyy

Relationship to applicant: _____

VOLUNTARY DEMOGRAPHIC INFORMATION

Please check the items that apply. It is the policy of the state of Delaware to assure equal and fair treatment in all aspects of healthcare for all of our residents. The information on this page will only be used to document and assess the effectiveness of our outreach and will not be used for eligibility determination. Your voluntary answers are requested. Thank you.

Marital Status

What is your current marital status?

a. __ Single b. __ Married/Civil Union c. __ Divorced
d. __ Separated e. __ Widowed f. __ Unmarried partnership

Ethnicity

Which of the following best describes your ethnicity?

a. __ Hispanic or Latino b. __ Non-Hispanic or Latino

Race

Which of the following best describes your racial heritage?

a. __ Caucasian/White d. __ African American/Black
b. __ Asian e. __ American Indian or Alaska native
c. __ Native Hawaiian or pacific islander f. __ Other

Language

How well do you speak English?

a. __ Very well b. __ Well c. __ Not well d. __ Not at all

Do you speak a language other than English at home?

a. __ No b. __ Yes, Spanish c. __ Yes, not Spanish, please specify: _____

Veteran Status

Are you a United States veteran?

a. __ Yes b. __ No

Citizenship

Are you a citizen or lawful resident of the United States of America? a. __ Yes b. __ No

Education

What is your highest level of education completed?

a. __ High school last grade completed d. __ Technical school
b. __ High school diploma/GED e. __ University or 4-year college
c. __ Community college/2-year degree f. __ Master program or above

Are you currently enrolled in school?

a. __ No b. __ Yes If yes, what level? _____

Employment

Are you currently working? a. __ No b. __ Part Time c. __ Full Time

What is your occupation? _____

Income

What is your annual household income?

a. __ Less than $20,000 d. __ $60,000 to $79,999
b. __ $20,000 to $39,999 e. __ $80,000 to $99,999
c. __ $40,000 to $59,999 f. __ $100,000 or above

Public Assistance

Are you currently enrolled in a public assistance program such as the DE food supplement program, health insurance, child care assistance, energy assistance program, or any other public assistance program?

a. __ No b. __ Yes Which program(s)? _____

Low Income Charge Request

If you believe that you qualify for the low income fee schedule, and wish to be considered for a lower application fee, you must provide supporting financial information, such as copies of your most recent tax returns, copies of W-2 forms, other documents showing current income. Total annual gross household income and the number of people living in the household will be requested in order to approve a reduced rate. To avoid denial of your application or delay in processing, please call the program to request a low income packet.

Required Documents

These documents must be submitted with your patient application:

Delaware driver's license or state-issued photo identification card

☐ ID number _____ Issue date _____ (mm / dd / yyyy) Expiration date _____ (mm / dd / yyyy)

A legible ***copy*** of your Delaware driver's license OR state-issued photo identification card should be ***sent*** with the application submission; the ***original document*** must be available for ***visual inspection*** when registry card is issued.

☐ Medical information release consent form

☐ Physician certification - enter date written (must be within 90 days of application) _____ (mm / dd / yyyy)

If you have selected a caregiver, you must also submit the following documents for that caregiver:

Delaware driver's license or state-issued photo identification card

☐ ID number _____ Issue date _____ (mm / dd / yyyy) Expiration date _____ (mm / dd / yyyy)

A legible ***copy*** of your Delaware driver's license OR state-issued photo identification card should be ***sent*** with the application submission; the ***original document*** must be available for ***visual inspection*** when registry card is issued.

☐ Caregiver Application form ☐ Patient Authorization form

☐ **Copy** of caregiver's birth certificate (verifying caregiver applicant is at least 21 years old)

☐ Statewide and nationwide criminal history screening background clearance reports for the caregiver (for further information, contact the program)

Patient's Attestation Statement

_____ initial I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.

_____ initial I agree to notify the Medical Marijuana Program, in writing (use the "Change Form"), within 10 days of any changes to the information provided.

_____ initial I attest that I will not divert marijuana to any individual or entity that is not allowed to possess marijuana pursuant to Title 16 of the Delaware Code, Chapter 49A.

_____ Patient signature

_____ Date of signature

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Medical Marijuana Program

DPH/HSP office use only

Date received _____
Staff initials _____
Date verified _____
Staff initials _____

Physician verified in good standing?
☐ Yes ☐ No

Please print clearly and answer all of the questions. Patients, please have your physician complete the entire form. This form should be submitted with your Application to the Medical Marijuana Program at the address on the first page of application instructions. **Faxed and electronic copies will not be accepted. NOTE: This does NOT constitute a prescription for marijuana. The patient's application for the medical marijuana program must be received by DPH within 90 days of the signature date on this form.**

Physician Certification

Patient Information

Physician instructions: please complete this section with the information in the patient's record.

Name _____
Title First Middle initial Last Suffix(es)

Patient's address
Apt#/development/apartment name _____
Number & street _____
City _____ State ____ County _____ ZIP code _____
Patient's date of birth _____ Patient's phone number _____
mm / dd / yyyy

Debilitating Medical Condition

These are the ONLY qualifying debilitating medical conditions. Check all that apply to this patient.

- ☐ Cancer
- ☐ Positive status for human immunodeficiency virus (HIV positive)
- ☐ Acquired immune deficiency syndrome (AIDS)
- ☐ Decompensated cirrhosis (Hepatitis C)
- ☐ Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease)
- ☐ Agitation of Alzheimer's disease
- ☐ Post-traumatic stress disorder (PTSD) (physician MUST be a licensed psychiatrist)

A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following:

- ☐ Cachexia or wasting syndrome
- ☐ Severe, debilitating pain, that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects
- ☐ Intractable nausea
- ☐ Seizures
- ☐ Severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis

Any other medical condition or its treatment **added by DHSS** as provided for in 4906A of the Delaware code. Please specify below.

- ☐ Other: please specify _____

417 FEDERAL STREET • JESSE COOPER BUILDING, SUITE 205 • DOVER DELAWARE 19901
(302) 744-4749 • MEDICALMARIJUANADPH@STATE.DE.US

Physician Information

Name _____
Title First Middle initial Last Suffix(es)

Practice/group name (if applicable) _____
Address (suite/room number, etc.) _____
Number & street _____
City, state, & zip _____
Phone number _____ Fax number _____
License number _____ License state ____ License type _____
Email address (not required) _____
Length of time the patient has been under your care (years &/or months) _____

Physician Certification

I, _____, (the physician):
Have made or confirmed a diagnosis of a debilitating medical condition, as defined in Title 16, Chapter 49A of the Delaware Code (4902A (3)), for the qualifying patient.

_____ initials

Have established a bona fide physician-patient relationship with (patient) _____
This qualifying patient is under my care, either for his/her primary care or for his/her debilitating medical condition as is listed on this form. This bona-fide physician-patient relationship is not limited to authorization for the patient to use medical marijuana or consultation for that purpose.

_____ initials

Have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days. I completed an assessment of the qualifying patient's current medical condition, including presenting symptoms related to the debilitating medical condition I diagnosed or confirmed.

_____ initials

Have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians from the previous 12 months. I have established a medical record for the qualifying patient with regard to his/her medical condition, and his/her continued treatment under my care.

_____ initials

Have explained the potential risks and benefits of the medical use of marijuana to the qualifying patient.

_____ initials

Physician's attestation
I, _____, hereby certify that I am a physician duly licensed to practice medicine. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition or symptoms associated with the debilitating medical condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient. I attest that the information provided in this written certification is true and correct.

_____ _____
Physician's signature (no signature stamps accepted, blue ink only) Date of signature

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Medical Marijuana Program

DPH/HSP office use only

Date received _____
Staff initials _____
Date verified _____
Staff initials _____

Patient verified with certifying physician?
☐ Yes ☐ No

Patients, please complete and sign the following release statement. This form will allow the Medical Marijuana Program staff to verify information with the certifying physician relating to your qualified medical condition. This form must be submitted with your patient enrollment application. If this form is omitted, your application will be considered incomplete and will be denied. **Faxed and electronic copies will not be accepted.**

Release of Medical Information Form

PATIENT RELEASE REQUEST

I, _____, (patient's name):
hereby authorize the Delaware Department of Health and Social Services, Medical Marijuana Program to discuss my medical condition, including treatment records, test results, and evaluations specific to _____ (the patient's qualifying condition)
with my certifying medical provider (print certifying medical provider's name below)
(Physician's first name:) _____ Last name: _____
and, if applying under **post-traumatic stress disorder**, my licensed psychiatrist
(Psychiatrist's first name:) _____ Last name: _____
I understand that I may revoke this release at any time. I also understand that if I wish to revoke this authorization, I must do so in writing to the Delaware Medical Marijuana Program, and that revocation may result in the inability of the program to certify me as a Medical Marijuana Program participant. Additionally, I understand that the revocation will not apply to information that has already been released in response to this authorization. The information disclosed pursuant to the authorization is subject to potential re-disclosure by the recipient, and will not be protected by the HIPAA privacy rule. I understand that this disclosure is voluntary and that signing this form is not necessary in order to receive treatment from the Delaware Department of Health and Social Services. This release is required; however, to verify my eligibility for the Medical Marijuana Program.

By signing this release I certify that I am aware that the program may provide verification of my enrollment status with law enforcement; but only for the purpose of verifying that a person is lawfully enrolled in the Medical Marijuana Program, or in the event that the Medical Marijuana Program administrator or designee has reason to believe that a qualified patient-applicant may have violated an applicable law.

This authorization will expire in one (1) year unless a different expiration date prior to one year is specified here: / / .

_____ _____
Patient's signature Date of signature

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